CLAYTON PARK CHIROPRACTIC CENTRE INC.
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Health History Forms – Infant / Child

Child's Name: ______________________________ Date: ______________________

Parent(s) Name: ____

Sibling(s) Name(s) & Age(s): ____

Address: ____ City: ______________

Postal Code: ______________ Cell #: ________________ Home #: ________________

We offer text reminders for your appts. If interested, who is your cell phone provider?________________

Email address: ____

Date of Birth: ______________ Age: ______ □ M □ F Referred by: ____________________
mm/dd/yyyy

Has your child ever received chiropractic care? □ Y □ N If yes, please list previous DC's name and last visit date? ____

Name and phone number of Medical Doctor: ________________________________

Date of last MD visit & Reason: ____

Present Health Complaints/Concerns

Please complete as appropriate, if there are no complaints/concerns please go to Family Health History

Major Health Complaint:
____

Minor Health Complaint:
____

When did the problem begin?
____

Is the problem: □ Occasional □ Constant □ Intermittent

Does the problem radiate? □ Yes □ No, If yes, where?
____

What makes this worse?
____

What makes this better?
____

Is the problem worse during a certain time of the day? □ Yes □ No If yes, when?
____
____

Does this interfere with the child's: □ Sleep □ Eating □ Daily Routine

Is this becoming worse? ____

Other professionals seen for this condition? ________________________________

Results with that treatment? ____

Family Health History

Please note any health problems (eg. Cancer, hereditary conditions, heart disease, etc.) that are present in:

Mother's family: ______________________________

Father's family: ______________________________

Sibling(s): ______________________________

Since problems that chiropractors look for and detect can be related to many types of stressors, the following information is also very important to us.

Physical Stressors

Any traumas to the mother during pregnancy? (eg. Falls, accidents, etc.) □ Yes □ No
If yes, please explain: ______________________________

Any evidence of birth trauma to the infant?
□ Bruising □ Odd shaped head □ Stuck in birth canal
□ Cord around neck □ Fast or Excessively long birth □ Respiratory Depression

Any falls from sofa's, beds, change tables, etc? □ Yes □ No, If yes, please explain:
____
____

Any hospitalizations or surgeries? □ Yes □ No, If yes, please explain:
____
____

Any sports played?
____

Is a school backpack used? □ Yes □ No, If yes, Is it packed: □ Heavy □ Light

Chemical Stressors

Was this child breast-fed? □ Yes □ No, If yes, how long?
____

At what age was formula introduced? ____________________ What formula? ____________
At what age was cow's milk introduced? ______________________________
At what age was solid food introduced? ____________________ Type of foods? ____________
Food/Juice Intolerance? □ Yes □ No, If yes, what type? ______________________________
During pregnancy, did the mother? Smoke □ Yes □ No How much? ____________________
Drink □ Yes □ No How much? ______________________________
Any illnesses during the pregnancy? □ Yes □ No, If yes, what illnesses? ____________
____
____

Any supplements taken during pregnancy? □ Yes □ No, If yes, what supplements?
____

Any drugs taken during pregnancy? □ Yes □ No, If yes, what drugs?
____

Often Seemingly Unrelated Symptoms Can Manifest As Other Health Concerns

(Please check if your child has had any of the following)

□ Headaches □ Loss of Taste □ Weight gain □ Upper back pain
□ Dizziness □ Light sensitivity □ Dental Problems □ Neck Pain
□ Fainting □ Face Flushed □ Fevers □ Low Back Pain
□ Fatigue □ Cold Sweats □ Heart Palpitations □ Radiating Pain
□ Irritability □ Bronchitis □ Chest Pressure □ Stiffness
□ Depression □ Pneumonia □ Breast Pain □ Reduced Mobility
□ Loss of Balance □ Difficulty Breathing □ Frequent Colds □ Numbness in leg(s)
□ Loss of Concentration □ Shortness of Breath □ Sinus Congestion □ Numbness in feet
□ Loss of memory □ Asthma □ Sore Throats □ Numbness in hand(s)
□ Ears Buzzing □ Urinary Problems □ Ear Pain/Infections □ Weakness
□ Poor Coordination □ Constipation □ Allergies □ Muscle cramps
□ Vision Changes □ Diarrhea □ Heartburn □ Sleeping Problems
□ Loss of Smell □ Weight Loss □ Bloating/ Gas
□ Other:
____
____

History of Birth

What was the child's gestational age at birth? _________ weeks

Birth weight: __________lbs __________oz length __________ (inches)

Was your child's birth: □ at home □ in a birthing centre □ in a hospital?

Was the birth considered: □ medical □ midwife?

What was the duration of the labour and delivery? __________ hours

Was the child born: □ Cephalic (head first) □ Breech (feet first)?

Were there any complications? □ Yes □ No, If yes, please explain:
____
____

Please check any assistance, which was used during the birth:
□ Forceps □ Vacuum Extraction □ C-Section □ Episiotomy

Was labour: □ Spontaneous □ Induced

Were medications, or epidurals, given to the mother during birth? □ Yes □ No, If yes, what was given? ____

APGAR score: at Birth ______/10 After 5 minutes _____/10 (if known)

Growth and Development

Was the infant alert and responsive within 12 hours of delivery? □ Yes □ No, If yes, please explain: ____
____

At what age did the child:
Respond to sound ______ Follow an object ______ Hold up head ________
Vocalize ______ Sit alone ______ Teeth ______ Crawl ______ Walk ______

Do you consider the child's sleeping pattern normal? □ Yes □ No, If no, please explain:

Any ultrasounds? □ Yes □ No, How many and reasons for being done?

Any invasive procedures during pregnancy? (eg. Amniocentesis, CVS, etc.) Please explain:

Any pets at home? □ Yes □ No, If yes, what kinds?

Any smokers in the home? □ Yes □ No

Vaccination History

Did your child receive vaccinations? □ Yes □ No, If yes, which ones?

Any negative reactions? □ Yes □ No, If yes, please explain:

Any antibiotics given? □ Yes □ No, How many courses and why?

Psychosocial Stressors

Any difficulties with lactation? □ Yes □ No, If yes, what are/were they?

Any problems with bonding? □ Yes □ No, If yes, what are/were they?

Any behavioural problems? □ Yes □ No, If yes, what are/were they?

Any: □ night terrors □ sleep walking □ difficulty sleeping
Age of child when she/he began daycare?

Average number of hours of television per week?

Do you feel that your child's social and emotional development is normal for their age? □ Yes □ No, If yes, how?

If there are any other questions or concerns, which you have, you may write them in the space provided:

OFFICE FEE SCHEDULE & FINANCIAL POLICY

(Chiropractic prices are *not* subject to tax)

CHIROPRACTIC SERVICES:

	Dr. Doug + Dr. Sasha
Consultation (10min)	*NO CHARGE*
Initial Chiro Exam	$100.00
Chiro Adjustment	$61.00
Chiro Re-Assessment	$71.00
Chiro Reactivation	$71.00
Missed Appointment Charge	**$45.00**

FINANCIAL POLICY AND CHIROPRACTIC ACTIVE LIFE PLANS

We are committed to providing you with the best chiropractic care possible in a caring environment and have established our financial policies to achieve that goal. You will be expected to pay for your chiropractic care at the time the service is rendered unless you arrange a Chiropractic Active Life Plan in advance. These plans are designated to be the most cost effective way to keep you and your family as healthy as possible. Details of these plans will be discussed with you during your Report of Findings appointment.

REGISTERED MASSAGE THERAPY SERVICES:

½ HOUR SESSION (specific area)	$56.52 (plus tax) = $65.00
1 HOUR SESSION	$86.96 (plus tax) = $100.00
1 ½ HOUR SESSION	$134.78 (plus tax) = $155.00
2 HOUR SESSION	$173.91 (plus tax) = $200.00

If less than 24 hours notice is given to cancel Massage Therapy a FULL APPOINTMENT FEE will be charged

NO DIRECT BILLING – Our office does NOT direct bill to any insurance company therefore **PAYMENT IN FULL IS DUE** on date of service.

We accept exact cash, debit or credit cards (Visa & Mastercard only)

This office is **SCENT SENSITIVE.** Please refrain from wearing strong perfumes and aftershaves during your visit.

I, (printed name) ________________________________ have read and I understand the above policies.

______________________________ ______________________________

Patient signature (or guardian) **Date**